STATE OF RHODE ISLAND
DEPARTMENT OF HEALTH
BOARD OF MEDICAL LICENSURE AND
DISCIPLINE

No. C02-008A

In the matter of:
John A. Duncan, III, M.D.
License #: MD 08811

Consent Order

Pursuant to R.I. Gen. Laws §5-37-5.2, 1956, as amended, (1999 Reenactment) complaints were filed with the Board of Medical Licensure and Discipline (hereinafter referred to as "Board") charging John Duncan, III, M.D., Respondent, with violations of §5-37-5.1. An investigation was conducted by an Investigating Committee of the Board.

The following constitutes the Investigating Committee's Findings of Fact with respect to the professional performance of the Respondent.

Findings of Facts

1. The Respondent, John Duncan, III, M.D., was employed at Neurosurgery Foundation in Rhode Island. The Respondent is Board Certified in Neurological Surgery and Pediatric Neurosurgery. He is the Neurosurgeon-in-Chief at the Rhode Island Hospital. He has practiced this specialty in Rhode Island since 1995. The Board of Medical Licensure and Discipline received notification from Rhode Island Hospital that the

Respondent was the attending physician during an operative procedure. The intended surgery was scheduled for a right-sided burr hole drainage of a subdural hematoma and possible craniotomy. The actual operation was performed by a sixth year surgical resident and assisted by a fifth year resident under the supervision of the Respondent.

2. While the Respondent was scrubbing for surgery the sixth year resident hung the CT scan facing the wrong direction and prepared the patient for a left sided operation.

3. The patient is draped in a manner that exposes a small patch of exposed skin and it is not readily apparent which side is exposed once the patient is prepped.

4. The Respondent authorized the procedure after observing the drawn incision marks. After the burr hole was made and a small piece of bone removed, the resident opened the dura and reported to the Respondent that the clot was not visible. The Respondent immediately asked the resident to identify the surgical location. The Respondent learned that the wrong side had been done after reviewing the CT scan.

5. The correct operation was then performed. The patient did not suffer any brain damage as a result of this error and the incision healed without complication. The family was informed of the error that same day, steps were taken on a hospital wide basis to prevent

other such errors and the Respondent took a lead role in the program designed to prevent such errors in the future.

6. The Board finds that the Respondent, as the supervising attending surgeon, was responsible for correct identification of the surgical site even though the procedure was performed by residents in training and he conformed to existing hospital policy.

The parties agree as follows:

The Respondent is a physician licensed and doing business under and by virtue of the Laws of the State of Rhode Island, allopathic license No. MD08811.

(1) Respondent admits to the jurisdiction of the Board and hereby agrees to remain under the jurisdiction of the Board.

(2) Respondent has read this Consent Order and understands that it is a proposal of an Investigating Committee of the Board and is subject to the final approval of the Board. This Consent Order is not binding on Respondent until final ratification by the Board.

(3) Respondent hereby acknowledges and waives:

a. The right to appear personally or by counsel or both before the Board;

b. The right to produce witnesses and evidence in his behalf at a hearing;

c. The right to cross examine witnesses;

d. The right to have subpoenas issued by the Board;

e. The right to further procedural steps except for specifically contained herein;

f. Any and all rights of appeal of this Consent Order;

g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review;

h. Any objection to the fact that it will be necessary for the Board to become acquainted with all evidence pertaining to this matter in order to review adequately this Consent Order;

i. Any objection to the fact that potential bias against the Respondent may occur as a result of the presentation of this Consent Order.

(4) Acceptance of this Consent Order constitutes an acknowledgement by the Respondent that the Board found the facts set forth herein.

(5) This Consent Order shall become part of the public record of this proceeding once it is accepted by all parties and by the Board.

(6) Failure to comply with this Consent Order, when signed and accepted, shall subject the Respondent to further disciplinary action.

(7) The Respondent agrees to use his position as Neurosurgeon-in-Chief to work towards solving problems of relating to medical errors and in seeking preventive solutions. To this end he will participate in a working group of physicians who will study and make recommendations to the

Department of Health regarding reducing medical errors and wrong site surgery.

(8) This working group shall meet at dates and times over the next year as determined by the Board of Medical Licensure and Discipline and the Director of Health.

Signed this 30th day of JUNE, 2003.

John A. Duncan, III, M.D.

Ratified by the Board of Medical Licensure and Discipline at a meeting held on June 19th, 2003.

Patricia A. Nolan, MD, MPH
Director of Health